TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 03 -- 004

2. STATE: MAINE

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE(S)
8/1/03

5. TYPE OF PLAN MATERIAL *(CHECK ONE):*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 03 $ 3.3 million (5.6 million yearly reduction in outpatient being submitted separately)
b. FFY 04 $ ~~20 million~~ 12.5 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ATTACHMENT 4.19-A, ENTIRE SECTION

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable):*
ATTACHMENT 4.19- A, ENTIRE SECTION

SUBJECT OF AMENDMENT: AMEND HOSPITAL INPATIENT REIMBURSEMENT

11. GOVERNOR'S REVIEW *(Check One):*
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
COMMISSIONER, DEPT. OF HUMAN SERVICES

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
PETER WALSH

14. TITLE:
Acting Commissioner, Maine Department of Human Services

15. DATE SUBMITTED: SEPTEMBER 29, 2003

16. RETURN TO:

CHRISTINE ZUKAS-LESSARD
Acting Director, Bureau of Medical Services
#11 State House Station

442 CIVIC CENTER DRIVE
Augusta, ME 04333-0011

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: SEP 30 2003

18. DATE APPROVED: JUL - 6 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: AUG - 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL: Barbara Smith

21. TYPED NAME: Charlene Brown

22. TITLE: Deputy Director, CMSO

23. REMARKS: Federal impact has been reduced on the 179 form.

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A DEFINITIONS

A-1 Acute Care Critical Access Hospitals

A hospital licensed by the Department as a critical access hospital that is being reimbursed as a critical access hospital by Medicare.

A-2 Acute Care Non-Critical Access Hospitals

A hospital licensed by the Department as an acute care hospital that is not being reimbursed as a critical access hospital by Medicare.

A-3 Discharge

A member is considered discharged when the member is formally released from the hospital, transferred from one hospital to another, or dies in the hospital. For purposes of this Section, a member is not considered discharged if moved from one location within a hospital to another, or readmitted to the same hospital on the same day.

A-4 Distinct Psychiatric Unit

A unit within an acute care non-critical access hospital that specializes in the delivery of inpatient psychiatric services. The unit must be reimbursed as a distinct psychiatric unit as a subprovider on the Medicare cost report or must be comprised of beds reserved for use for involuntary commitments under the terms of a contract with the Department of Behavioral and Developmental Services. The claim must also be distinguishable as representing a discharge from a distinct psychiatric unit on the MaineCare claims processing system.

A-5 MaineCare Paid Claims History

A summary of all claims billed by the hospital to MaineCare for MaineCare eligible members that have been processed and accepted for payment by MaineCare. A record of these claims is kept in the Department's claim processing system.

A-6 Private Psychiatric Hospital

A hospital that is primarily engaged in providing psychiatric services for the diagnosis, treatment and care of persons with mental illness and is privately owned. The facility must be licensed as a psychiatric hospital by the Department of Human Services. A psychiatric hospital may also be known as an institution for mental disease.

A-7 Prospective Interim Payment (PIP)

The weekly (or quarterly in the case of state owned psychiatric hospitals) payment made to a non-state owned hospital based on the estimated total annual Department obligation as calculated below. For purposes of the PIP calculation, a MaineCare discharge for the most recently completed hospital fiscal year is one with a discharge date occurring within the hospital fiscal year and submitted prior to the time of calculation.

A-8 State Owned Psychiatric Hospital

A hospital that is primarily engaged in providing psychiatric services for the diagnosis, treatment and care of persons with mental illness and is owned and operated by the State of Maine. The facility must be licensed as a psychiatric hospital by the Department of Human Services. A psychiatric hospital may also be known as an institution for mental disease.

A-9 Transfer

A member is considered transferred if moved from one hospital to the care of another hospital. MaineCare will not reimburse for more than two discharges for each episode of care for a member transferring between multiple hospitals.

B GENERAL PROVISIONS

B-1 Inflation

For purposes of determining inflation, unless otherwise specified, the economic trend factor from the most recent edition of the "Health Care Cost Review" from Global Insight shall be used.

B-2 Reconciliation and Settlement

At reconciliation and settlement, the hospital will reimburse the Department for any excess payments; or the Department will reimburse the amount of any underpayment to the hospital. In either case, the lump sum payment must be made within 30 days of the date of the letter notifying the provider of the results of the year end reconciliation or settlement. If more than one year's reconciliation or settlement is completed in the same proceeding, the net amount must be paid. If no payment is received within thirty (30) days, the Department may offset prospective interim payments.

Hospitals are required to file with the DHS, Division of Audit a year-end cost report within five months from their fiscal year end. The cost report filing consists of: CMS Form 2552 or its equivalent, audited financial statements, and any other related documentation as requested by the DHS-Division of Audit. The cost report must include applicable MaineCare utilization and a calculated balance due to/from MaineCare.

C ACUTE CARE NON-CRITICAL ACCESS HOSPITALS

C-1 Prospective Interim Payment (PIP)

The Department of Human Services' total annual PIP obligation to the hospitals will be the sum of MaineCare's obligation for the following: inpatient services + inpatient capital costs + hospital based physician and graduate medical education costs + days awaiting placement. Third party liability payments are subtracted from the PIP obligation.

The computed amounts are calculated as described below:

A. Inpatient Services

The inpatient component is the sum of the following:

1. General Inpatient

The hospital specific discharge rate multiplied by the estimated number of discharges. The rate per discharge is determined by:

1) Determining a cost per discharge based on Medicare cost reports for each hospital's fiscal year ending between October 1, 1998 and September 30, 1999; 2) Inflating this cost per discharge to State fiscal year 2004; 3) Applying a discount factor to the inflated cost per discharge to ensure that total expenditures for inpatient services provided by acute care non-critical access hospitals were no greater than they were in State fiscal year 2003; and 4) adjusting rates for a subset of hospitals by allocating legislatively appropriated funds, of between $7,000,000 and $8,000,000. Hospitals included in this subset must be the top privately owned, non-critical access, acute care hospitals, as defined by having estimated SFY 04 inpatient prospective interim payments in excess of $2,000,000. The adjustment was initially set by trying to make payments made by state public purchasers more comparable in an effort to address Medicaid's historically relatively low reimbursement rates. This adjustment was amended to be provided to those hospitals with the highest historical total MaineCare inpatient reimbursement; with funds allocated based on historical data reflecting share of total MaineCare reimbursement. This adjustment will be reviewed at least annually.

2. Distinct Psychiatric Unit Inpatient

Discharges from distinct psychiatric units will be reimbursed at the rate specified in Appendix A per discharge. MaineCare will only reimburse at this rate when the member has spent the majority of his or her stay in the distinct unit. MaineCare will only reimburse for one discharge for a single hospital for one episode of care.

B. MaineCare's share of inpatient capital costs, inpatient hospital based physician and graduate medical education costs, and inpatient third party liability (TPL) are taken from the most recent hospital fiscal year end MaineCare cost report as filed with DHS Division of Audit, inflated to the current year.

C. MaineCare Member Days Awaiting Placement (DAP) at a Nursing Facility (NF)

Reimbursement will be made prospectively at the estimated statewide average rate per member day for NF services. The Department shall adopt the prospective statewide average rates per member day for NF services that are specified in 4.19D. The average statewide rate per member day shall be computed based on the simple average of the NF rate per member day for the applicable State fiscal year(s) and prorated for a hospital's fiscal year.

All of these data elements are taken from the most recent hospital fiscal year end MaineCare cost report as filed with DHS Division of Audit, inflated to the current year.

C-2 Interim Volume Adjustment

The hospital may request in writing or the Department may initiate a comparison of MaineCare claims data submitted in the first 150 days of the payment year to the projected number of discharges used in calculating the PIP payment. If there is a difference of at least five (5) per cent between the actual MaineCare inpatient volume and prospectively estimated MaineCare inpatient volume, an adjustment may be made to the PIP using actual discharge data.

C-3 Year End Interim Settlement

The Department of Human Services' year end interim settlement with a hospital is calculated using the same methodology as is used when calculating the PIP, except that the data source used for inpatient calculations will be discharges included in MaineCare paid claims history as measured by the Department. Other calculations will be based on the hospital's as-filed cost report and MaineCare paid claims history for the year for which reconciliation is being performed.

C-4 Final Settlement

The Department of Human Services' final settlement with a hospital is calculated using the same methodology as is used when calculating the PIP, except that the data source used for discharges will be those included in MaineCare paid claims history as measured by the Department. Other components will be based on the hospital's audited cost report from the Medicare fiscal intermediary and MaineCare paid claims history for the year for which reconciliation is being performed.

D ACUTE CARE CRITICAL ACCESS HOSPITALS AND STATE OWNED PSYCHIATRIC HOSPITALS

All calculations made in relation to acute care critical access hospitals must be made in accordance with the Tax Equity and Fiscal Responsibility Act (TEFRA), except as stated below, plus a DSH adjustment payment for eligible hospitals.

D-1 Prospective Interim Payment (PIP)

The Department of Human Services' total annual PIP obligation to the hospitals will be the sum of MaineCare's obligation of the following: inpatient services + days awaiting placement + hospital based physician + graduate medical education costs. Third party liability payments are subtracted from the PIP obligation.

These computed amounts are calculated as described below:

A. Inpatient Services

The total MaineCare inpatient operating costs from the most recent as-filed cost report.

B. MaineCare Member Days Awaiting Placement (DAP) at a Nursing Facility (NF) and NF Services Provided to a Member in a Swing-Bed Reimbursement

Reimbursement will be made prospectively at the estimated statewide average rate per member day for NF services. The Department shall adopt the prospective statewide average rates per member day for NF services that are specified in the Principles of Reimbursement for Nursing Facilities, MaineCare Benefits Manual Chapter III, Section 67. The average statewide rate per member day shall be computed based on the simple average of the NF rate per member day for the applicable State fiscal year(s) and prorated for a hospital's fiscal year.

C. MaineCare's share of hospital based physician + graduate medical education costs are taken from the most recent hospital fiscal year end MaineCare cost report as filed with DHS Division of Audit, inflated to the current year.

D-2 Interim Volume Adjustment

The hospital may request in writing or the Department may initiate a comparison of MaineCare claims data submitted in the first 150 days of the payment year to the projected number of discharges used in calculating the PIP payment. If there is a difference of at least five (5) per cent between the actual MaineCare inpatient volume and prospectively estimated MaineCare inpatient volume, an adjustment may be made to the PIP using actual discharge data.

D-3 Year End Interim Settlement

The Department of Human Services' year end interim settlement with a hospital is calculated using the same methodology as is used when calculating the PIP, except that the data sources used will be the hospital's as filed cost report and MaineCare paid claims history for the year for which reconciliation is being performed.

D-4 Final Settlement

The Department of Human Services' final settlement with a hospital is calculated using the same methodology as is used when calculating the PIP, except that the data sources used will be the hospital's audited cost report from the Medicare fiscal intermediary and MaineCare paid claims history for the year for which settlement is being performed.

E PRIVATE PSYCHIATRIC HOSPITALS

E-1 Prospective Interim Payment

Private psychiatric hospitals will be paid weekly prospective interim payments based on the Department's estimate of the total annual obligation to the hospital. The Department's total annual obligation shall be computed based on the hospital's negotiated percentage rate. The negotiated percentage rate shall be between 85% and 95% of the hospital's estimated inpatient charges, less third party liability.

E-2 Interim Volume Adjustment

The hospital may request in writing or the Department may initiate a comparison of MaineCare charges on claims submitted in the first 150 days of the payment year to the projected charges used in calculating the PIP payment. If there is a difference of at least five (5) per cent between the actual MaineCare inpatient charge data and prospectively estimated MaineCare charge data, an adjustment may be made to the PIP using actual charge data.

E-3 Final Settlement

The Department's total annual obligation with a hospital will be computed based on the hospital's negotiated percentage rate. The obligation amount shall be greater than or equal to eighty-five (85) percent but not more than ninety-five (95) percent of the hospital's actual MaineCare charges from paid claims history, less third party liability.

F OUT OF STATE HOSPITALS

The Department will reimburse out of state hospitals for inpatient services based on:

1. The MaineCare rate if applicable;
2. The lowest negotiated rate with a payor whose rate the provider currently accepts;
3. The provider's in State Medicaid rate;
4. A percentage of charges; or
5. A rate specified in MaineCare's contract with the provider.

Out of State providers must accept MaineCare reimbursement for inpatient services as payment in full for all services necessary to address the illness, injury or condition that led to the admission.

G DISPROPORTIONATE SHARE HOSPITALS

G-1 Eligibility for DSH Payments

A. Essential Non-State Public Acute Hospitals.

A hospital must meet all of the following criteria, as determined by the Department:

1. The hospital is a Non-State owned, publicly owned hospital;
2. The hospital is a licensed acute hospital located in the State of Maine; and
3. The hospital has a current MaineCare provider agreement.
4. The hospital must have a MaineCare utilization rate (MUR) of at least one percent.

B. Institutions for Mental Disease

The IMD (psychiatric hospital) must have a MaineCare utilization rate (MUR) of at least one percent.

C. Acute Care Hospitals, other than Essential Non-State Public Acute Hospitals

The hospital must a) have a a medicaid inpatient utilization rate at least one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the state (as defined in section 1923 b1A of the SSA or b have a low income inpatient utilization rate as defined in section 1923 b1b of the Social Security Act exceeding 25%.
For purposes of determining whether a hospital is a disproportionate share hospital in a payment year the department will use data from the hospital's medicare as-filed cost report for the same period to apply the standard deviation test. If at the time of final audit the as-filed cost reports prove to be inaccurate to the degree that a hospital's disproportionate share status changes, adjustments will be made at that time.

D. Calculation of MaineCare Utilization Rate (MUR)

The MaineCare utilization rate calculation is:

MUR % = 100 X M/T
M = Hospital's number of inpatient days attributable to MaineCare covered patients **T** = Hospital's total inpatient days

In calculating the inpatient MUR, the State will include newborn nursery days, whether billed under the mother's MaineCare identification number or the infants, days in specialized wards, including intensive and critical care units, administratively necessary days including days awaiting placement, and days attributable to individuals eligible for Medicaid in another State. The State will not include days attributable to MaineCare members between 21 and 65 years of age in institutions for mental disease, unless such days are reimbursable under MaineCare.

For purposes of determining whether a hospital is a disproportionate share hospital in a payment year the department will use data from the hospital's medicare as-filed cost report for the same period to apply the applicable MUR test. If at the time of final audit the as-filed cost reports prove to be inaccurate to the degree that a hospital's disproportionate share status changes, adjustments will be made at that time.

E. For All Hospitals

i) the hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the state plan. In the case of a hopsital located in a rural area that is an area outside of a MSA as defined by the Executive Office of Managment and Budget the term obstetrician includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

ii) the obstetric criteria in subsection i above, do not apply to hospitals in which the inpatients are predominantly individuals under 18 years of age or to hospitals that did not offer non-emergency obstetric services as of December 21, 1987.

G-2 Prospective DSH Payments

Subject to the Cap Adjustment described below, unless otherwise provided, the DSH adjustment will be 100% of the actual cost, as calculated using TEFRA and GAAP principles, of:

a) services furnished to MaineCare members, plus
b) bad debt and charity care as reported on the hospital's most recent audited financial statement, plus
c) cost associated with the downsizing of the State-run facilities, if applicable;

minus
payments made by the State for services furnished to MaineCare members.

For the essential non-state public acute care hospitals the DSH adjustment for services rendered during the period July 1, 2003 through June 30, 2005 will be 175% of applicable costs, minus state payments.

Cap Adjustment

The Centers for Medicare and Medicaid Services (CMS) establishes an aggregate cap on the DSH payment for which the State may claim federal financial participation (overall cap). Within that overall aggregate cap, there is a limit on the amount of DSH payment that may be made to IMDs (IMD cap).

1. IMD DSH Payments

   If the Department determines that aggregate payments, as calculated above, would exceed the IMD cap established by CMS, payments will be made to State-run facilities first. Remaining IMD DSH payments will be proportionately reduced for all remaining IMDs.

2. Acute Care DSH Payments

   If the Department, determines that aggregate payments to acute care hospitals, as calculated above, would exceed the overall cap established by CMS, less DSH payments to IMDs, then the Department will determine the amount of DSH allotment necessary to establish budget neutrality for any applicable federal waivers. After making this determination, the Department will use the remainder of the allotment, if any, to make DSH payments to essential non-state public acute care hospitals. If necessary, DSH payments to these facilities will be proportionately reduced. Remaining acute care DSH payments will be proportionately reduced for all remaining hospitals.

3. Proportionate Reduction

The Department will calculate the proportionate reduction by applying the original DSH payment percentage determined for each hospital to the applicable DSH payment amount (cap) available.

G-3 Final DSH Adjustment

The Department of Human Services' total year end DSH obligation to a hospital is calculated using the same methodology as is used when calculating the prospective DSH adjustment, except that the data source used will be the hospital's audited cost report data, audited financial statement, and actual MaineCare claims from paid claims history for the year for which reconciliation is being performed.

H. SWING BED FOR NURSING FACILITY (NF)

H-1 Reimbursement to Hospitals

Reimbursement to hospitals for the provision of NF servies to a patient ina swing bed shall be made at the estimated statewide average rate per patient day for NF services.

H-2 Establishment of the Estimated Statewide Average Rate Per Patient Day

See attachment 4.19-D.

H-3 Ancillary Services

Reimbursement to hospitals for ancillary services provided to Medicaid-eligible recipients staying in swing-beds will be in accordance with these Principles of Reimbursement.